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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **HELEN M. CURTIS,** **AKA HELEN MARGARET CURTIS,** **AKA HELEN MARGARET STERLING** **12665 Willowbrook Lane** **Moreno Valley, CA 92555** **Registered Nurse License No. 412458** Respondent.	Case No. 2013-748 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On April 30, 1987, the Board of Registered Nursing issued Registered Nurse License Number 412458 to Helen M. Curtis, also known as Helen Margaret Curtis and Helen Margaret Sterling (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and expired on December 31, 2010, and has not been renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
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> (a) Unprofessional conduct, which includes, but is not limited to, the following:
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> . . . .
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.
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> . . . .

COST RECOVERY

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CAUSE FOR DISCIPLINE

(Out Of State Discipline)

8. Respondent has subjected her license to disciplinary action under Code section 2761, subdivision (a)(4), in that she has had a professional license disciplined in another state. The circumstances are that her Washington registered nurse license has been disciplined in a disciplinary action entitled *In the Matter of Helen M. Curtis, Credential No. RN.RN.00051326.* The State of Washington Department of Health Nursing Care Quality Assurance Commission (Washington Commission) issued Findings Of Fact, Conclusions Of Law and a Final Order Of Default in Case No. M2009-361, dated April 21, 2010, for unprofessional conduct in violation of Revised Code of Washington (RCW) section 18.130.180, and violations of standards of nursing conduct or practice, pursuant to Washington Administrative Code (WAC) section 246-840-710.

9. Based on the evidence before it, the Washington Commission made the following Findings of Fact:

a. On September 10, 1973, the State of Washington issued Respondent a credential to practice as a registered nurse. Respondent's credential expired on November 30, 2008, but remains subject to renewal.

b. At all times relevant to these allegations, Respondent was working at Allenmore Hospital in Tacoma, Washington. Under Allenmore's administration and documentation policy, controlled substances were unit of use and could not be used for separate multiple doses. Allenmore's policy on wasting unused medications was to have two (2) licensed staff witness the disposal of controlled substances and automated dispensing system (Pyxis) wastage was to be documented in Pyxis.

c. On or about August 18, 2006 at 0012, Respondent removed morphine sulfate 10 mg from the Pyxis for Patient A. Patient A's Medication Administration Record (MAR) reflected the administration of 2 mg of morphine sulfate at 0020. No wastage was documented, leaving 8 mg of morphine sulfate unaccounted for.

d. On or about August 18, 2006 at 0532, Respondent removed morphine sulfate 10 mg from the Pyxis for Patient A. Patient A's MAR reflected the administration of 2

mg of morphine sulfate at 0530. Wastage of 6 mg of morphine sulfate was charted and witnessed in Pyxis, leaving 2 mg of morphine sulfate unaccounted for.

e. On or about August 18, 2006, Respondent removed hydromorphone from the Pyxis for Patient B in the following quantities, and at the following times: 2 mg at 0302 and 2 mg at 0608, a total of 4 mg. The doses were not charted as administered in Patient B's MAR, and no wastage was documented, leaving 4 mg of hydromorphone unaccounted for.

f. On or about August 19, 2006 at 2352, Respondent removed hydromorphone 2 mg from the Pyxis for Patient C. Patient C's MAR reflects the administration of 1 mg hydromorphone on 8/20/06 (charted time illegible). No wastage was documented, leaving 1 mg of hydromorphone unaccounted for.

g. On or about August 20, 2006 at 0208, Respondent removed hydromorphone 2 mg from the Pyxis for Patient C. The dose was not charted as administered in Patient C's MAR, and no wastage was documented, leaving 2 mg of hydromorphone unaccounted for.

h. On or about August 20, 2006 at 0329, Respondent removed hydromorphone 2 mg from the Pyxis for Patient C. Respondent charted her initials and a time of 0325 in the MAR, but did not document the amount of hydromorphone administered to Patient C, and no wastage was documented in Pyxis.

i. On or about August 20, 2006 at 0012, Respondent removed 2 mg hydromorphone from the Pyxis for Patient D. Respondent charted her initials and a time of 0010 in the MAR, but failed to document the amount of hydromorphone administered to Patient D, and no wastage was documented in Pyxis.

j. On or about August 20, 2006 at 0513, Respondent removed 2 mg hydromorphone from the Pyxis for Patient D. Respondent charted her initials and a time of 0530 in the MAR, but did not document the amount of hydromorphone administered to Patient D, and no wastage was documented in Pyxis.

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k. On or about August 22, 2006 at 2345, Respondent removed hydromorphone 2 mg from the Pyxis for Patient E. The dose was not charted as administered in Patient E's MAR, and no wastage was documented, leaving 2 mg of hydromorphone unaccounted for.

l. On or about August 23, 2006 at 0530, the Respondent removed hydromorphone 2 mg from the Pyxis for Patient E. The dose was not charted as administered in Patient E's MAR, and no wastage was documented, leaving 2 mg of hydromorphone unaccounted for.

m. On or about August 24, 2006, Respondent removed hydromorphone from the Pyxis for Patient F in the following quantities, and at the following times: 2 mg at 0052 and 2 mg at 0456, a total of 4 mg. The doses were not charted as administered in Patient F's MAR, and no wastage was documented, leaving 4 mg of hydromorphone unaccounted for.

n. On or about August 25, 2006 at 0018, Respondent removed hydromorphone 2 mg from the Pyxis for Patient F. Respondent charted her initials and a time of 0020 in the MAR, but did not document the amount of hydromorphone administered to Patient F, and no wastage was documented in Pyxis.

o. On or about August 25, 2006 at 0606, Respondent removed hydromorphone 2 mg from the Pyxis for Patient F. The dose was not charted as administered in Patient F's MAR, and no wastage was documented, leaving 2 mg hydromorphone unaccounted for.

p. On or about August 28, 2006 at 2357, Respondent removed hydromorphone 2 mg from the Pyxis for Patient G. Respondent charted her initials and a time of 0000 in the MAR, but did not document the amount of hydromorphone administered to Patient G, and no wastage was documented in Pyxis.

q. On or about August 29, 2006 at 0615, Respondent removed hydromorphone 2 mg from the Pyxis for Patient G. Respondent charted her initials and a

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time of 0630 in the MAR, but did not document the amount of hydromorphone administered to Patient G, and no wastage was documented in Pyxis.

r. On or about August 28, 2006 at 2358, Respondent removed hydromorphone 2 mg from the Pyxis for Patient H. The dose was not charted as administered in Patient H's MAR, and no wastage was documented, leaving 2 mg hydromorphone unaccounted for.

s. On or about August 29, 2006 at 0306, Respondent removed hydromorphone 2 mg from the Pyxis for Patient H. The dose was not charted as administered in Patient H's MAR, and no wastage was documented, leaving 2 mg hydromorphone unaccounted for.

t. On or about August 29, 2006 at 0616, Respondent removed hydromorphone 2 mg from the Pyxis for Patient H. Respondent charted her initials and a time of 0625 in the MAR, but did not document the amount of hydromorphone administered to Patient H and no wastage was documented in Pyxis.

u. On or about September 5, 2006 at 0004, Respondent removed hydromorphone 2 mg from the Pyxis for Patient I. Respondent charted her initials and a time of 0125 in the MAR, but did not document the amount of hydromorphone administered to Patient I, and no wastage was documented in Pyxis.

v. On or about September 7, 2006, Respondent removed hydromorphone from the Pyxis for Patient J in the following quantities, and at the following times: 2 mg at 0314 and 2mg at 0636, a total of 4 mg. The doses were not charted as administered in Patient J's MAR, and no wastage was documented, leaving 4 mg of hydromorphone unaccounted for.

w. On or about September 8, 2006, Respondent removed hydromorphone from the Pyxis for Patient J in the following quantities, and at the following times: 2 mg at 0154 and 2 mg at 0425. The doses were not charted as administered in Patient J's MAR, and no wastage was documented, leaving 4 mg of hydromorphone unaccounted for.

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x. On or about September 11, 2006, Respondent removed hydromorphone from the Pyxis for Patient K in the following quantities, and at the following times: 2 mg at 0125 and 2 mg at 0443, a total of 4 mg. Patient K was not a patient at Allenmore Hospital on September 11, 2006; Patient K had transferred out of Allenmore Hospital on May 12, 2006. No wastage was documented, leaving 4 mg of hydromorphone unaccounted for.

y. On or about September 13, 2006, Respondent removed morphine sulfate from the Pyxis for Patient L in the following quantities, and at the following times: 10 mg at 0018, 10 mg at 0246, and 10 mg at 0520. On September 13, 2006, Patient L did not have a current physician order for morphine sulfate. The doses were not charted as administered in Patient L's MAR, and no wastage was documented, leaving 30 mg of morphine sulfate unaccounted for.

z. On March 5, 2010, the Commission served Respondent with a copy of the following documents at Respondent's last known address:

1) Statement of Charges;

2) Notice of Your Legal Rights;

3) Answer to Statement of Charges and Request for Settlement and Hearing (Answer).

aa. The Answer was due in the Adjudicative Clerk Office by March 25, 2010, RCW 18.130.090.

bb. The Adjudicative Clerk Office had not received the Answer. On March 31, 2010, the Adjudicative Clerk Office issued a Notice of Failure to Respond.

cc. The Commission has no reason to believe Respondent is now on active military service.

10. Based on the evidence before it, the Washington Commission made the following Conclusions of Law:

a. The Commission has jurisdiction over Respondent and over the subject matter of the proceeding, RCW section 18.130.040.

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b. Respondent did not file a request for hearing within the time allowed, RCW section 18.130.090, subdivision (1). Respondent is in default, and the Commission may issue a final order based on the evidence presented, RCW sections 18.130.090, subdivision (1), and 34.05.440.

c. Respondent committed unprofessional conduct in violation of RCW section 18.130.180, subdivision (4), subdivision (7), and subdivision (12), and WAC section 246-840-710, subdivision (2)(b), subdivision (2)(c), and subdivision (2)(e).

d. The above violations provide grounds for imposing sanctions under RCW section 18.130.160.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 412458, issued to Helen M. Curtis, aka Helen Margaret Curtis, aka Helen Margaret Sterling;

2. Ordering Helen M. Curtis to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: March 13, 2013

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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